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WHO/UNICEF/UNFPA Coordinating Committee on Health

Report of its first session held at the headquarters of the World Health Organization

Geneva, 3-4 July 1998

Summary

The present document contains the report of the first session of the WHO/UNICEF/UNFPA Coordinating Committee on Health, which met for the first time on 3-4 July 1998 at WHO headquarters in Geneva. The report also contains the Committee's terms of reference

* E/ICEF/1998/12.

WHO/UNICEF/UNFPA Coordinating Committee on Health CCH(98)/Report
First Meeting
Geneva, 3-4 July 1998 4 July 1998

REPORT OF WHO/UNICEF/UNFPA COORDINATING COMMITTEE ON HEALTH (CCH)

WHO headquarters, Geneva
3-4 July 1998

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I. OPENING OF THE MEETING (Agenda item 1)

1. Dr Kawaguchi, Director, Division of Interagency Affairs, WHO, opened the session and welcomed the participants.

2. Mr de Silva, WHO Executive Board, was unanimously elected Chairman. Dr Fikri, member of the WHO Executive Board, Dr Pulido de Briceño, member of the UNICEF Executive Board, and Dr Papineau Salm, member of the UNFPA Executive Board, were elected Rapporteurs.

3. The WHO/UNICEF/UNFPA Coordinating Committee on Health (CCH) adopted the Agenda.

4. Dr Nakajima, Director-General of WHO, welcomed all participants to the First Meeting of the WHO/UNICEF/UNFPA Coordinating Committee on Health (CCH), recently established to enhance partnerships and coordinated action, as well as efficient use of resources by the three organizations. The Committee would be able to build on the achievements of the UNICEF/WHO Joint Committee on Health Policy and its rich experience of almost fifty years. He wished the new coordinating body every success in carrying out its duties, to maximize political commitment and public support to women's and children's health and optimize the use of the human and financial resources thus made available.

5. During this session CCH would be considering three main public health issues relevant to its mandate: safe motherhood, vitamin A deficiency and adolescent health.

6. Ten years had passed since the launch of the Safe Motherhood Initiative. The challenge of reducing maternal mortality had become widely recognized and the causes of the problem were much better understood. In many parts of the world, however, the knowledge gained had yet to be put into practice. Maternal and perinatal care was an area in which the difference between the haves and the have-nots was blatant. Health systems had to be strengthened to include appropriate case management at local level and reliable referral services for obstetric complications. Making quality services available was vital, but increasing the use made of these services was just as important. Poverty, lack of education, and women's lack of power to make decisions about their own health also contributed to maternal mortality. Political commitment in developing countries was crucial to ensure safe motherhood for all women.

7. The health status of individuals was influenced by health events which occurred earlier in their lives, and in the lives of their parents. Women's health and their access to reproductive health care and counselling largely determined the health status of their babies. Proper nutrition was an essential determinant of both the mother's and the child's health. Most micronutrient deficiencies could be linked to economic and cultural factors. Vitamin A deficiency (VAD) in particular was a public health problem in many low-income countries and its health consequences were severe, not only in preschool children but also in pregnant women. Data on the prevalence of VAD in women were still scarce but pointed to VAD as an important factor of maternal mortality and poor outcomes of pregnancy and lactation. There was a pressing need to take action to ensure that progress could be made in all countries. One of the objectives of the meeting would be to define ways in which the three organizations could combine their efforts to achieve broader implementation of a multipronged control strategy. This would include vitamin A supplementation, food fortification, and dietary improvement, particularly through the promotion of breastfeeding and support for the consumption and local production of foods rich in vitamin A.

8. Obviously, the need to ensure proper care, nutrition and lifestyles did not stop with childhood. It was critical that appropriate care should be provided to adolescents and that they should be encouraged to adopt safe lifestyles, to prepare the way for good health during adulthood.

9. Despite many achievements, the task ahead was formidable. Everyone stood to gain from enhanced coordination of resources and activities. On the basis of that principle, collaboration had first been established between WHO and UNICEF and had become extremely successful, thanks especially to the extraordinary generosity of the late Jim Grant and his selfless dedication to the cause of children. Collaboration between WHO, UNICEF and UNFPA would, he was confident, carry that work forward with great competence, renewed energy and full commitment to the humanistic values that defined the mission of the three agencies.

10. Ms Bellamy, Executive Director of UNICEF, said that, when historians looked back on the international development scene in the last few years of the century, the attempts made to increase coordination at the global, regional and national levels would stand out. Developing countries were demanding better coordination of international efforts and, at the country level, many governments were more strongly asserting their right to be the coordinators. Democratization, together with the increasing scarcity of development resources, made duplication of effort and wasteful overlap less acceptable than ever before, and the communications revolution, and relative ease of international travel had made the weaknesses of international coordination more visible than ever before.

11. Better coordination of international development work within the United Nations system was a central part of United Nations reform. Many were familiar with the United Nations Development Assistance Framework (UNDAF) process, which was being implemented in 18 pilot countries. In the area of health, the Sector Wide Approaches (SWAPS), or Sectoral Investment Programmes (SIPS) were being welcomed by developing countries and supported by key donor governments. The three agencies were having to decide how best to adapt their approaches to development to those ambitious and all-embracing approaches.

12. The UNICEF/WHO Joint Committee on Health Policy, one of the first high level coordinating mechanisms established within the United Nations system, had played a crucial role in establishing common policies and frameworks for programme support and implementation, and had served as a focal point to review key policies and indicators of progress, and made recommendations on ways in which progress could be accelerated.

13. In the wake of the International Conference on Population and Development, it was appropriate that UNFPA had joined WHO and UNICEF in the Coordinating Committee on Health. It was also appropriate that the agenda covered three issues which were highly relevant for each of the three organizations: safe motherhood, adolescent health, and vitamin A (which seemed to be just as important for women's reproductive health as it was for child survival). They were not only central to support for existing commitments, such as those made at the 1990 World Summit for Children, the International Conference on Population and Development, Cairo, 1994, and in Beijing in 1995 at the Fourth World Conference on Women, but they would also be central to the challenges that lay ahead.

14. In addition to those three areas, she believed that each of the agencies should re-examine its support to other priority areas. Rolling back malaria and tobacco control would require the full support of all three agencies to succeed. There was also an immediate need to review and strengthen support to countries battling the AIDS pandemic, which was devastating women's and children's health and undermining the capacity of the health system in ways never seen before.

15. In its efforts to strengthen the coordination of the work of the three agencies in health, CCH should build upon other mechanisms: UNDAF, the United Nations Theme Groups established at the country level, and UNAIDS. There was a need to take stock of interagency coordination mechanisms that had worked well and to learn lessons from those that had worked less well.

16. Coordination mechanisms that inhibited initiative and innovation and which imposed numerous layers of review and approval should be avoided. Coordination was easiest when organizations shared common goals and objectives and freely shared information. While developing consensus at the global level was essential, the real test of whether coordination mechanisms were effective was what happened at the country level, particularly how the rights of particularly disadvantaged children, families and communities were met and protected. She hoped that the meeting would lead to a clear understanding of how the deliberations of CCH would be translated into accelerated improvements in the health of children and women.

17. Dr Sadik, Executive Director of UNFPA, said that it was an honour and a privilege to address the first meeting of the WHO/UNICEF/UNFPA Coordinating Committee, an historic meeting that had been long in coming. About three years ago, the UNDP/UNFPA Executive Board had first considered the possibility of becoming a member of the UNICEF/WHO Joint Committee on Health Policy, the predecessor of this Committee. In March 1996 the UNDP/UNFPA Executive Board had reaffirmed the need for close collaboration and asked UNFPA to explore ways to further strengthen coordination in order to develop better coordinated health policies and programmes, including reproductive health, in the context of the follow-up of the International Conference on Population and Development. In fact, the report of the JCHP special session of May 1996 had convinced the UNDP/UNFPA Executive Board that the most effective way to strengthen interagency coordination would be for the UNDP/UNFPA Executive Board to become a member of the Committee. That report recounted successful and useful deliberations concerning such issues as maternal mortality, and adolescent health including adolescent reproductive health, both of which were priority areas for UNFPA and in which UNFPA was a key player.

18. For UNFPA the work of the Committee held great promise. It would help to sharpen the focus of interagency collaboration and coordination in achieving health and related social goals. Indeed, the three organizations had all worked together extremely well, especially in developing the social services agenda. The programme of action of the International Conference on Population and Development had placed reproductive health in the context of primary health care, thus recognizing it as an essential component of any minimum package of health services. It was, therefore, important for the three agencies to make sure that their activities contributed to the development of the health system in a given country.

19. In the shorter term, she hoped that the Committee could facilitate agreement among WHO, UNICEF and UNFPA on common approaches, a clearer delineation of their respective roles and responsibilities, a better exchange of methodologies, data and knowledge, and greater harmony in collaboration at the country level in implementing the various goals.

20. No goal was more noble or more urgent than to save the lives of women, men and children, or to improve the quality of their lives by providing them with access to health care, including reproductive health care. The Committee had the power to make a difference in those areas, especially in helping developing countries to build their own capacity to provide basic health care. It could also help to improve efficiency and effectiveness in the use of limited programme resources by making optimal use of the comparative advantages of the extensive field structures of UNICEF and UNFPA and of the technical expertise of WHO to plan, deliver and monitor quality health services.

21. She looked forward to working with the Committee and pledged to the Committee UNFPA's full support and cooperation. UNFPA was eager to begin what it was to be hoped would be a long and fruitful involvement in the collective efforts of the three Executive Boards to strengthen interagency coordination in the vital area of health.

II. REVIEW OF TERMS OF REFERENCE OF WHO/UNICEF/UNFPA COORDINATING COMMITTEE ON HEALTH (Agenda item 2)

22. The document under consideration[1] recalled almost fifty years of WHO/UNICEF collaboration through JCHP, and the expansion of JCHP to include UNFPA. It outlined the steps taken to establish the Terms of Reference and included the text approved by the WHO Executive Board at its 100th session (resolution EB100.R2), as well as the recommendations of the Executive Boards of UNICEF and UNDP/UNFPA (Decisions 1997/27 and 97/28, respectively).

23. With the agreement of CCH, a draft text was circulated providing the text approved by the WHO Executive Board (resolution EB100.R2), with amendments proposed by the UNICEF Executive Board. CCH agreed to this consolidated text which would be submitted as CCH's recommendation on the Committee's Terms of Reference to the three Executive Boards (see Annex 1).

24. The increasing involvement of the World Bank in the health sector and sector-wide approaches, and the need for coordination on policy, technical and programme support issues was discussed.

25. CCH recommended that, at the secretariat level, there should be close cooperation with the World Bank on relevant issues covered by CCH to facilitate greater operational coordination at country level. Informal participation of the World Bank in CCH on specific agenda items would be welcome.

III. REVIEW OF WHO RESOLUTIONS, UNICEF DECISIONS AND UNDP/UNFPA DECISIONS (Agenda item 3)

26. The document under discussion[2] presented resolutions and decisions relevant to improving the health status of women and children, adopted by the World Health Assembly in May 1997 and May 1998 and by the WHO Executive Board in May 1997 and January 1998, and the decisions of the UNICEF Executive Board in 1997. Being the first time that the UNDP/UNFPA Executive Board was represented on the Coordinating Committee, as the successor committee to JCHP, the document also presented pertinent decisions taken by the UNDP/UNFPA Executive Board in 1995, 1996 and 1997.

WHO resolutions

Fiftieth World Health Assembly, May 1997

WHA50.19 Prevention of violence
WHA50.29 Elimination of lymphatic filariasis as a public health problem
WHA50.34 Malaria prevention and control
WHA50.35 Eradication of dracunculiasis
WHA50.36 African trypanosomiasis

27. The above resolutions had been brought to the attention of the Thirty-first session of JCHP, 19-20 May 1997, and were therefore not reviewed again.

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[1] Document CCH(98)/2.

[2] Document CCH(98)/3 Rev.1.

WHA50.12 Establishment of the International Vaccine Institute

28. The importance of the resolution for the three organizations was stressed.

WHA50.21 World Tuberculosis Day

29. The resolution was noted.

Executive Board, 100th session, May 1997

EB100.R1 Health systems development for the future

30. The collaboration between UNICEF and WHO in health systems development was noted. It was pointed out that, although the mandate of UNFPA focused primarily on reproductive health, including family planning, UNFPA had already been active in contributing to health systems in countries, since reproductive health services were part of basic services. Indeed, the three organizations should work to develop common strategies and approaches to improve health systems at country level.

31. It was suggested that the three organizations should collaborate at county level on the following aspects:

- inventory of health resources and infrastructure;
- development of human resources through training and upgrading of skills for primary health care structures;
- drafting of job descriptions;
- establishment of a structure to ensure supervision of staff;
- re-establishment of the role of hospital services in the primary health care framework;
- common logistics systems;
- development of common health statistics for monitoring programmes.

32. While the report on the two-year work plan endorsed by JCHP in 1997 would cover collaboration between WHO and UNICEF, the involvement of UNFPA in activities would be warmly welcomed.

EB100.R2 WHO/UNICEF/UNFPA Coordinating Committee on Health

Executive Board, 101st Session, January 1998

Decision EB101(11) Report on the UNICEF/WHO Joint Committee on Health Policy

Fifty-first World Health Assembly, May 1998

WHA51.8 Concerted public health action on anti-personnel mines

33. The above resolutions and decision were noted.

WHA51.11 Global elimination of blinding trachoma

34. With regard to the above resolution in particular, it was pointed out that the elimination of blinding trachoma was outside the mandate of UNFPA. In general, UNFPA would only participate in areas that were related to its work.

WHA51.12 Health promotion
WHA51.13 Tuberculosis
WHA51.14 Elimination of transmission of Chagas disease
WHA51.15 Elimination of leprosy as a public health problem
WHA51.17 Emerging and other communicable diseases: antimicrobial resistance

35. The above resolutions were noted.

WHA51.18 Noncommunicable disease prevention and control

36. The importance of the resolution was emphasized.

WHA51.22 Collaboration within the United Nations system and with other intergovernmental organizations: Health of children and adolescents
WHA51.24 International Decade of the World's Indigenous People
WHA51.28 Environmental matters: strategy on sanitation for high-risk communities

37. The above resolutions were noted.

UNICEF Executive Board decisions

Decision 1997/17 Report on the meeting of the UNICEF/WHO Joint Committee on Health Policy

38. The decision was noted.

Decision 1997/19 Ensuring children's rights to survival, protection and development in Africa
Decision 1997/20 Follow-up to the World Summit for Children

39. The plight of orphan children was emphasized. In Africa, because of HIV/AIDS and armed conflict, there were so many orphans that they could no longer be cared for by extended families. Priorities had been set to accelerate programme activities.

Decision 1997/27 Proposed Terms of Reference of the World Health Organization/ UNICEF/United Nations Population Fund Coordinating Committee on Health

40. The above decision had been discussed under Agenda item 2.

UNDP/UNFPA Executive Board decisions

Decision 95/15 **Programme priorities and future directions of the United Nations Population Fund in the light of the International Conference on Population and Development**

41. The importance of the decision was emphasized.

Decision 95/36 **UNFPA: Global contraceptive commodity programme**
Decision 96/3 **Global contraceptive commodity programme**

42. The above decisions were noted.

Decision 96/15 **Allocation of resources to country programmes of UNFPA**

43. The importance of the decision was emphasized.

Decision 96/17 **Inter-Agency coordination in health policy and programming**
Decision 96/38 **Coordination in health policy and programming**
Decision 97/1 **UNICEF/WHO/UNFPA Coordinating Committee on Health**
Decision 97/7 **Revision of UNFPA Financial Regulations**
Decision 97/28 **Functioning of the Coordinating Committee on Health**

44. The above decisions were noted.

IV. SAFE MOTHERHOOD (Agenda item 4)

45. The document under discussion[1] analysed progress in reducing maternal mortality as of the mid-decade, the current status and remaining challenges, and lessons learned. A number of key actions to accelerate progress were suggested. In reviewing the document before the CCH, it was noted that the report was based on previous work prepared for the UNICEF/WHO Joint Committee on Health Policy and that it largely reflected actions supported by UNICEF and WHO. It was brought to the attention of the Committee that there also had been extensive UNFPA involvement in those areas of safe motherhood reflected in paragraph 16 of the document and it was agreed that the report[1] should more fully reflect this.

46. In introducing the document, it was pointed out that the recently held meeting in Colombo to review the Safe Motherhood Initiative after ten years had further developed international consensus on priorities to accelerate progress, and these were summarized. It was also pointed out that WHO, UNFPA and UNICEF, together with the World Bank, had collaborated to produce a joint statement on reduction of maternal mortality, which was expected to be finalized within the next few weeks. That statement set out the details of an interagency consensus on the problem of maternal mortality, its causes, and priorities to improve the situation.

47. CCH requested that more emphasis should be placed on improving safe motherhood in the context of the life cycle, starting with improvement of the health and nutrition of young and adolescent girls. Greater attention also needed to be given to the effect of female genital mutilation, violence against girls and women, unsafe abortion and low levels of education as factors contributing to maternal mortality and morbidity.

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[1] Document CCH(98)/4.

48. CCH recognized that the previous approach of identifying and focusing narrowly on individuals identified to be at high risk of maternal mortality had not worked, as life-threatening delivery complications might also arise in low-risk women. There was a need, however, to continue to recognize that there were still clear risk factors which called for attention, such as adolescent pregnancies and too close birth spacing. It should be noted that it was not just rural women who had high risks of maternal mortality, but that in many areas urban women were at high risk as well.

49. It was necessary to ensure that women themselves, and their communities, were fully involved in the design of plans to improve safe motherhood. There was also a need to ensure an appropriate balance of approaches between the provision of essential obstetric care, the mobilization of communities and preventive actions. The fact that the document emphasized the need to strengthen district hospitals was welcomed. There was also a need to ensure that safe motherhood activities included action to educate and support girls and women in ways that enabled them to avoid unsafe and unwanted pregnancies, and unsafe abortion.

50. Following discussion, CCH agreed that the following key actions should be taken to make motherhood safer:

(a) Improve the situation of girls and women throughout the life cycle by, among other things, improving the nutrition and health of young and adolescent girls, preventing female genital mutilation and violence against girls and women, improving the status of women, and strengthening the education of girls.

(b) Strengthen pregnancy-related services at all levels of the district health system and improve access to essential care for obstetric complications, including emergencies, at health centres and hospitals. This will involve upgrading skills at the health centre level and reinstituting a referral service to district hospitals. It will be essential to support the full participation of men and women in the community in the planning, implementation and monitoring of actions.

(c) Strengthen access to voluntary family planning information and services in order to enable women to choose if and when to become pregnant.

(d) Strengthen the functioning of the referral system by linking women's groups, communities, health centres and first-level referral hospitals.

(e) Improve the quality of reproductive health care, including the technical competence of the providers, supplies of drugs and equipment, and communication between providers and clients. Strengthen the training of professional midwives and increase their placement in underserved areas.

(f) Target Information, Education and Communication (IEC) activities not only to women, but also to men, families, and others in the community whose attitudes and actions can influence the health of women. Increase community awareness of hazards of pregnancy and childbirth through social mobilization for planning pregnancy and safe delivery and organizing transport for women who experience complications during delivery.

(g) Provide adolescents (particularly young women) with the information, skills, support from peers and family, and access to health services they require.

(h) Since under-nutrition including anaemia has a negative impact on maternal health and nutrition, as well as on birth weight, give more attention to improving nutrition for girls and women.

(i) The complications of unsafe abortion are a major cause of maternal mortality in many countries. Whatever the legislation, there are ways to address unsafe abortion and countries should be supported in this area.

(j) Continue to develop and test innovative approaches to measuring maternal mortality and to monitoring and evaluation, including both quantitative and qualitative methodologies.

(k) Strengthen efforts to link the prevention of HIV/AIDS as well as mother to child transmission of HIV/AIDS to other safe motherhood activities.

(l) Take a coherent and long-term approach to making motherhood safer, which combines and balances all of the above actions at the country level.

51. CCH endorsed WHO/UNICEF/UNFPA collaboration on safe motherhood, including:

- the harmonization of policies in the draft joint statement which is under development, and continuing collaborative work on guidelines, tools and other materials issued either jointly or separately by the respective organizations;

- the further development and expansion of global advocacy for safe motherhood in the context of reproductive health.

52. CCH further called for the promotion of strengthened WHO/UNICEF/UNFPA collaboration on safe motherhood, through their respective Executive Boards, paying particular attention to:

- the harmonization of implementation at country level in the framework of national and district plans of action or priorities, within and outside the health sector, through, for example, United Nations Theme Groups on Health.

- strengthening collaboration at the regional level through WHO and UNICEF regional offices and UNFPA country support teams.

- strengthening the focus on maternal and newborn survival in health sector reform processes, including sector investment plans and sector-wide approaches, ensuring that safe motherhood programmes receive a minimum level of investment in these, in a reproductive health context.

- strengthening collaboration with other partners in the field, particularly the World Bank.

53. CCH suggested that the three secretariats should work jointly to develop a strategy for the reduction of maternal and newborn mortality, with milestones and targets, in the reproductive health context.

V. VITAMIN A (Agenda item 5)

54. The document under discussion[1] reviewed the strategies to eliminate vitamin A deficiency as a public health problem, drew attention to the most effective interventions, and proposed targets and key actions.

55. In presenting the document, it was noted that vitamin A deficiency affected primarily preschool children and women. In addition to causing ocular lesions, it was a major factor affecting child survival and safe motherhood. Out of 118 countries where vitamin A deficiency was a public health problem, a substantial number had not yet taken any control measures. Given the importance of that public health problem, there was a need to accelerate progress in reducing vitamin A deficiency.

56. The following key actions were proposed:

(a) Establish targets for implementing the plan of action.

(b) Make vitamin A supplementation the centrepiece of the strategy for vitamin A deficiency control. Existing programmes should be used as much as possible, in particular immunization and reproductive health.

(c) Explore further possibilities for food fortification with vitamin A, support breastfeeding and any measures to increase dietary vitamin A content, support operational research particularly on topics related to women and vitamin A deficiency, and address the issue of multiple-vitamin and mineral supplementation.

57. During its discussion, the Committee considered the following issues:

- immediate action should take place in advance of the proposed targets being set;
- the emphasis on further research should be viewed in the context of new knowledge, although new topics such as vitamin A deficiency in women or vitamin A deficiency in relation to mother-to-child HIV transmission have recently grown in importance and raised many questions that need to be scientifically addressed;
- the need to take every opportunity to link the distribution of vitamin A supplements to other ongoing activities; for example, collaboration was currently being developed with EPI programmes to deliver vitamin A supplements with immunization contacts;
- the importance of sustainability;
- the role of advocacy to make countries more aware of the problem and the possibilities of finding a solution.

58. CCH noted the strong consensus among the three organizations concerning the strategy to be followed to accelerate progress in eliminating vitamin A deficiency. The Committee endorsed the strategy and made the following recommendations:

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[1] Document CCH(98)/5.

(a) In countries where vitamin A deficiency is likely, vitamin A supplementation programmes should be supported. Programmes to fortify foods and improve diets also need to be encouraged.

(b) Special attention should be given to advocacy in order to mobilize governments to tackle vitamin A deficiency.

(c) Continuing research on a limited number of priority topics is still needed.

(d) Vitamin A supplements should be viewed within the wider context of multiple-vitamin and mineral supplements.

(e) More attention should be given to the sustainability of national programmes for the control of vitamin A deficiency.

VI. ADOLESCENT HEALTH AND DEVELOPMENT (Agenda item 6)

59. The document under discussion[1] reviewed the history of WHO/UNICEF/UNFPA collaboration in the area of adolescent health and development, and in particular the work of the joint WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health.

60. CCH agreed that the health of adolescents was an area of critical concern to the three organizations and endorsed the recommendations of the WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health.

61. In discussion, it was pointed out that adolescents were not the problem, the problem was that their rights were not met.

62. CCH considered that the three organizations should develop and implement strategies for effective dialogue with and involvement of adolescents in all phases of programming (analysis, assessment and action), appreciating that they were a key resource of civil societies.

63. Mention was made of the fact that many adolescent health issues were sensitive (for example, sexuality, substance abuse, and violence) and that many adults had ambivalent attitudes towards those matters.

64. CCH recognized that public advocacy was still required to dispel myths, misunderstandings and misconceptions about adolescent health and development.

65. In view of the range of antecedents and diverse problems confronting adolescents, a multisectoral approach was essential (health, education, media, etc.). Multi-agency involvement was therefore essential, and effective formal and informal mechanisms for coordination at country level needed to be strengthened or developed. It would be important to strengthen current collaboration by WHO, UNICEF and UNFPA at global, regional and national levels, in line with their mandates and strategic advantages, and to include collaboration with other United Nations organizations that had an interest in the health and development of adolescents, such as UNDCP, UNESCO, UNHCR and ILO.

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[1] Document CCH(98)/6.

66. Adolescents were not a homogeneous group. While all adolescents were vulnerable, some were particularly vulnerable and disadvantaged (for example, school drop-outs, those not living at home, those using illicit drugs and alcohol, adolescents who had never been to school, exploited adolescents, etc.). Many adolescents were not prepared for the opportunities that surrounded them, and many more did not even have access to such opportunities.

67. CCH agreed that all adolescents required information, skills, access to quality services, a safe environment and opportunities to participate, but that a situation analysis/assessment was needed to identify the most disadvantaged adolescents who would often require specific strategies to meet their rights to health and development.

68. As there was a need to work together on certain health problems throughout the life cycle, ways in which a focus on adolescent health and development could be strengthened in health sector reform in countries, including sector investment plans, were needed. Attention was drawn to the need for support for the development of quality services that responded to a range of health problems (for example, sexual and reproductive health, tuberculosis, nutrition), and for a focus on adolescents in national programmes, such as those dealing with safe motherhood, HIV/AIDS, and tobacco.

69. It was stressed that parents and other significant caring and supportive adults were essential for adolescents' health and development. Adolescents were "children" as defined by the Convention on the Rights of the Child, and remained dependent on adults to meet their rights to health and development. Programmes should therefore be developed to support parents and develop their parenting skills, as well as sensitizing adults in the community to respond to the needs of adolescents for health and development.

70. Because adolescence had been identified as a key period of the life cycle, there had to be a concerted effort to accelerate national programmes for adolescent health and development. At regional level, there was a need for better coordination and pooling of technical resources.

71. CCH recognized that, while there was a need to focus on prevention, that was not always possible. When prevention was not possible, it was important to consider harm reduction, the separation of high-risk behaviours, and delaying the onset of high-risk behaviours.

72. CCH stressed that development was at the heart of the health of adolescents. Adolescents should be an important focus for community development programmes and adolescents' development should be an important focus for programmes directed to adolescents. It would be important to identify ways in which adolescent health and development, including adolescent sexual and reproductive health, could both contribute to and benefit from current efforts to strengthen collaboration within the United Nations, for example through Theme Groups and the United Nations Development Assistance Framework (UNDAF).

VII. OTHER MATTERS (Agenda item 8)

Coordination at country level

73. The importance of effective coordination at country level was stressed. Such coordination was essential to ensure that the actions recommended by CCH were implemented in reality.

74. The potential promising results anticipated from the United Nations Development Assistance Framework were mentioned. Whether working together on the same activities or undertaking complementary activities, it was important for the efforts of the three organizations to be directed towards the same priority targets.

Next meeting of CCH

75. Recognizing the importance of following up the Committee's recommendations to ensure that action was taken on them at country level, CCH decided to hold its next meeting in the second half of 1999.

76. Regarding the agenda for that meeting, it was stressed that sufficient time should be allowed for useful discussion of each item. It was also observed that less time might be required for consideration of some items compared to others.

77. The following topics were suggested for possible inclusion in the agenda of the next meeting:

- health systems development,
- implementation of CCH recommendations at country level,
- strategy coordination,
- pregnancy and HIV/AIDS,
- indicators,
- safe motherhood (follow-up),
- vitamin A and micronutrients (follow-up),
- malaria.

78. CCH agreed that the agenda would be drawn up by the three secretariats at an intersecretariat meeting.

VIII. CLOSURE OF MEETING (Agenda item 9)

79. Mr de Silva, Chairman of CCH and member of the WHO Executive Board, thanked participants for their valuable views and ideas, which he hoped would already have been put into action by the time of the Committee's next meeting. The excellent working atmosphere and cordial relations between the three organizations augured well for health in the twenty-first century.

80. Ms Bellamy, Executive Director of UNICEF, endorsed those remarks and expressed appreciation to the members of the three Executive Boards, and to the staff of the three organizations for their contributions to outlining the actions to be implemented.

81. Dr Sadik, Executive Director of UNFPA, pledged UNFPA commitment to following up the recommendations of the meeting, and paid tribute to the Chairman for his attentiveness and good chairmanship.

She also thanked the members of the three Executive Boards, and the staff of the organizations for their active participation.

82. Dr Antezana, Assistant Director-General, WHO, speaking on behalf of the Director-General of WHO, expressed gratitude to the Chairman, the members of the three Executive Boards and the executive heads of UNICEF and UNFPA. He was sure that the motivation and commitment exhibited at the Committee's first meeting would lead to tangible improvements in the health sector.

ANNEX 1

WHO/UNICEF/UNFPA COORDINATING COMMITTEE ON HEALTH[1]

TERMS OF REFERENCE

1. The WHO/UNICEF/UNFPA Coordinating Committee on Health (CCH) shall meet biennially, or in special session if required, normally in Geneva. The Committee shall be chaired in rotation by a member of the Executive Board of each organization; WHO, as the lead agency in international health, will chair the first session.

2. The role of the Committee will be:

- to facilitate the coordination of health policies and programmes of the three organizations;

- to review the overall needs for strategic, operational and technical coordination in the fields of maternal, child, adolescent and women's health, with a prioritized focus on disease and health ramifications based on WHO mortality and morbidity statistics, and reproductive health, including family planning and sexual health, to ensure regular exchange of information in these areas and to make recommendations to the respective Executive Boards for follow-up action by the secretariats, as appropriate, with due regard for the respective mandates of the organizations involved;

- to promote consistency in implementation strategies and activities among the three organizations and with other partners, for the maximum benefit of Member States, especially at the country level within the context of the Resident Coordinator system and, in this context, to ensure that these are guided by the overall policy framework for health development as defined by the World Health Assembly.

- to receive and review progress and assessment reports presented by the Director-General of the World Health Organization, the Executive Director of UNICEF or the Executive Director of UNFPA, on activities pertaining to the health of children, young people and women, with a prioritized focus on disease and health ramifications based on WHO mortality and morbidity statistics, including reproductive health, and to review any orientation of strategy that may be necessary to meet agreed objectives, with due regard for the respective mandates of the agencies involved;

- to consider matters of common concern to WHO, UNICEF and UNFPA which the Executive Boards or the secretariats of the respective organizations may refer to this Committee;

- to report to the WHO, UNICEF and UNFPA Executive Boards on the foregoing matters.

3. The WHO/UNICEF/UNFPA Coordinating Committee on Health shall be composed of 16 members of the Executive Boards of the three organizations, such members being selected by their respective Boards on the basis of one from each region of the organization concerned.

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[1] Text recommended by the First Meeting of CCH to be submitted to the Executive Boards of the three organizations. It is based on the text approved by WHO Executive Board (resolution EB100.R2), 16 May 1997 plus the amendments proposed by UNICEF Executive Board, September 1997 (Decision 1997/27).

4. WHO shall provide the Secretariat for the Committee and, in consultation with UNICEF and UNFPA, jointly convene intersecretariat meetings to prepare the agenda and supporting documentation for the sessions of the Committee.

5. Further intersecretariat meetings may be convened in alternate years, where appropriate with other organizations active in health, to ensure a coordinated approach at country level.

ANNEX 2

LIST OF PARTICIPANTS

WHO Executive Board Members

Dr R. Daniel
Secretary of Health
Ministry of Health
Rarotonga
Cook Islands
(Alternate to Dr J. Williams)

Dr P. Dossou-Togbe
Directeur adjoint de Cabinet
Ministère de la Santé, de la Protection sociale
et de la Condition féminine
Cotonou
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Medical Centre for Postgraduate Education
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Dr A. Meloni
Director-General
Oficina de Financiamiento, Inversiones y
Cooperacion Externa
Ministerio de Salud
Lima
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Mr N. S. de Silva (**Chairman**)
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Annex 2

UNICEF Executive Board Members

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Public Health Physician
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Dr Mercedes Pulido de Briceño (**Rapporteur**)
Venezuela

Dr Petr Struk
Director
Department of Medical Science and Education
Ministry of Health
Czech Republic

Dr Ali Jaffer Bin Mohammed Suleiman
Director-General
Ministry of Health
Oman

UNFPA Executive Board Members

Mr Sam Aymer
Minister of Health and Civil Service Affairs
Antigua and Barbuda

Dr John Katatu Musyimi Mulwa
Permanent Secretary, Ministry of Health
Director of Health Services
Republic of Botswana

Dr Aagje Papineau Salm (**Rapporteur**)
Senior Adviser for Health and Population
Ministry of Foreign Affairs
The Netherlands

Dr Suwanna Warakamin
Director, Family Planning and Population Division
Department of Health
Ministry of Public Health
Thailand

Annex 2

UNICEF

Ms Carol Bellamy, Executive Director
Mr David Alnwick, Chief, Health Section
Dr Bruce Dick, Senior Youth Health Adviser, Health Section
Ms Cecilia Lotse, Secretary of the Executive Board

UNFPA

Dr Nafis Sadik, Executive Director
Mr S. Bavelaar, Senior External Relations Officer, European Office
Dr N. Dodd, Chief of the Technical Branch, Technical and Policy Division (TPD)
Dr C. Gardiner, Senior Technical Officer, Technical and Policy Division (TPD)
Mr R. Snyder, Senior Officer, Executive Board Branch, Information and External Relations Division (ERO)

WHO

Dr Hiroshi Nakajima, Director-General
Ms C. Abou-Zahr, Division of Reproductive Health (Technical Support) (RHT)
Dr S. Archarya, Regional Adviser, Maternal and Child Health, WHO Regional Office for South East Asia, (MCH/SEARO)
Dr F.S. Antezana, Assistant Director-General, Deputy Director-General a.i. (ADG-DDGa.i.)
Dr B. de Benoist, Programme of Nutrition (NUT)
Dr J. Clements, Expanded Programme on Immunization (EPI)
Ms B.J. Ferguson, Chief, Adolescent Health and Development (ADH)
Mrs D. Halvorsen, Division of Interagency Affairs (INA)
Mr G. Hartl, Health Communications and Public Relations (HPR/INF)
Dr S. Holck, Director, Division of Reproductive Health (Technical Support) (RHT)
Mr J.A. Hueb, Division of Operational Support in Environmental Health, Rural Environmental Health (EOS/REH)
Ms I. Hoskins, Ageing and Health (AHE)
Dr Y. Kawaguchi, Director, Division of Interagency Affairs (INA)
Dr V.K. Lepakhin, Assistant Director-General (ADG)
Dr J. Liljestrand, Chief, Maternal and Newborn Health/Safe Motherhood (MSM)
Mr Y. Ling, Programme of Nutrition (NUT)
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Dr D.G. Makuto, Director, Division of Analysis, Research and Assessment (ARA)
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Dr E. Pupulin, Chief, Rehabilitation, Division of Health Promotion, Education and Communication (HPR)
Dr B.-I. Thylefors, Director, Programme for Prevention of Blindness and Deafness (PBD)
Mr T. Topping, Legal Counsel (LEG)
Dr T. Türmen, Executive Director (EXD)
Mr E. Webster, Division of Intensified Cooperation with Countries and Peoples in Greatest Need (ICO)
Dr R. Williams. Division of Emerging and Other Communicable Diseases Surveillance and Control (EMC)

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